GEORGIA BOARD OF EXAMINERS OF LICENSED PRACTICAL NURSES

237 Coliseum Drive
Macon, Georgia 31217
(478) 207-1620

PROBATION SELF REPORT

NOT CONFIDENTIAL

Name of Licensee			
License Number		Phone Number	
Address			

Date of Report: _____

Aftercare Facility name	
Facilitator name & title	
Facility Address	
Telephone number	

Health Status _____
_____
_____
(If you are taking any prescription controlled substances, your doctor must submit a report to the board.)

Employer name	
Supervisor name & title	
Facility Address	
Employer Phone Number	

Special Remarks or concerns or requests:
_____
_____
_____
_____

Signature _____ Date _____

For Board Use Only			
Review		Result	

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(478) 207-1620

EMPLOYER QUARTERLY REPORT

Please complete this form and return it to the address shown above by reporting periods ending on March 31st, June 30th, September 30th, and December 31st.

Name of Employee			
License Number		Phone Number	
Address			

Date of Report: _____ Date began work _____

Is employee working as a LPN?
Supervisor's name & title:

Job Performance Area	S	U	N/A	Comments
Quality of Work				
Attendance				
Professionalism				
Attitude				
Compliance with Aftercare				
Compliance with Controlled Substance Restrictions				

Has there been a random Drug screen _____ Yes _____ No
If yes, were results negative? _____ Yes _____ No

Signature of Preparer	
Printed Name & Title of Preparer	
Facility Name Address	
Employer Phone Number	

For Board Use Only			
Review		Result	

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CONTINUING CARE/AFTERCARE/SUPPORT GROUP REPORT

Please complete this form and return it to the address shown above by reporting periods ending on March 31st, June 30th, September 30th, and December 31st.

Name of Attendee			
License Number		Phone Number	
Address			

Date of Report: _____ Date Joined Support Group _____

Number and type of 12 Step Meetings attended per week	
Number of group meetings attended since last report	
Number of group meetings missed since last report	

Compliance Area	S	U	N/A	Comments
Attendance				
Participation				
Attitude				
Adheres to Rules				
Reports prescribed medications				
Other				

Has there been a random Drug screen? _____ Yes _____ No
If yes, were results negative? _____ Yes _____ No
Please attach a certified copy of the drug screen.

Signature of Facilitator	
Printed Name of Facilitator	
Agency Name, Address	
Phone Number	

For Board Use Only			
Review		Result	